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The Obese Patient:

The Psychosocial Burden of Obesity and the Role of Bariatric Surgery

INTRODUCTION

In the United States, obesity is an epidemic that threatens all age groups. An estimated 32 million women and 26 million men in the US are obese, which is defined as having a body mass index (BMI) of 30 or higher.¹ Obesity is a proven risk factor for hypertension, type II diabetes, and several cancers; comorbid conditions include joint and musculoskeletal pain and pulmonary dysfunction. An estimated 300,000 deaths annually are attributed to obesity.² According to the Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, the medical and related costs of obesity in the US in 2000 were greater than \$117 billion.¹ What we don't often discuss is the enormous psychosocial cost of obesity.

Obesity has been found to seriously affect social and



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psychological functioning, particularly in the morbidly obese.³ Many obese individuals perceive prejudice and discrimination due to their obesity and face the stigma of obesity every day. Those who are morbidly obese (more than 100% over ideal weight) often seek bariatric surgery as a treatment modality. Prior to surgery, patients undergo a thorough psychological evaluation. What are the red flags and how does this evaluation affect a patient's candidacy for surgery? Does bariatric surgery improve psychosocial functioning?

The following case illustrates a morbidly obese man who has been overweight most of his life. He has also been diagnosed with dysthymic disorder and treated with psychopharmacologic and psychotherapeutic modalities. During psychotherapy, he began to consider the option of bariatric surgery. Like many who are obese, he spent years of his life attempting to lose weight through dieting and weight loss programs. Nevertheless, he remained obese and he suffered from both medical and psychosocial complications. With this case as a focus, this article will review the literature on the psychosocial consequences of obesity, the preoperative psychological evaluation for bariatric surgery candidates, the psychiatric conditions that are contraindications for surgery, and the impact of obesity surgery on psychosocial functioning.

CASE PRESENTATION

Psychiatric history and diagnosis. Charles, a 33-year-old never-married man, presented to a new psychiatrist to begin intensive psychotherapy for a long history of dysthymic disorder. He first experienced an episode of

depression following the unexpected death of his only high school friend. He saw the school counselor for several weeks of supportive therapy. Over the next decade, he reported that he never returned to feeling like his “normal” self. He described chronic symptoms consistent with dysthymia, including depressed mood most days of the week, never feeling as happy as those around him, low energy, low self esteem, difficulty making decisions, chronic guilt, and episodes of depression (which included increased tearfulness, insomnia, anorexia, and anergia). He eventually sought treatment from his family physician who initiated sertraline (Zoloft®) at 50mg daily, and then titrated the dose to 100mg daily.

Charles never married, although he was engaged for approximately one year to a woman he met while enrolled in classes at a community college. When she unexpectedly ended their relationship, his depressive symptoms worsened and he contemplated suicide. He immediately went to see his family physician who increased his sertraline to 150mg and referred him for psychotherapy. In the beginning of therapy, Charles complained of chronic low self-esteem, limited success in his job, and chronic problems with interpersonal relationships. He described himself as shy and very inhibited in social situations; he felt inadequate, inferior, and unappealing around most people. He believed that others only see him as a fat man who is “lazy and doesn't care about his appearance.” While engaged to his fiancée, he always feared she would leave him for someone who was more attractive. These fears of rejection kept him from dating in high school, despite his interest in several peers.

Charles reported that he had been overweight since childhood. Both his parents were overweight, but neither was morbidly obese. Charles gained a significant amount of weight in his early teenage years and subsequently began to struggle with his body image and self-esteem. His parents reacted negatively to his weight gain; they would call him names such as “lazy” and “pig.” His parents ridiculed him when clothes shopping and often refused to buy clothing that appropriately fit. He recalled how they even tried to bribe him with money to lose weight. One summer, he was sent to “fat camp,” and his parents were disappointed when he returned having only lost 10 pounds.

KEY POINT—What Are the Psychosocial Consequences of Obesity?

Obese individuals face psychosocial pressures that are widespread and intense. Pejorative attitudes toward obesity continue to be reinforced with societal beliefs that obesity develops from a lack of willpower, from laziness, and from emotional problems.⁴ Even physicians have reported their own obese patients to be “weak-willed, ugly, and awkward.”⁵ As a result, obese individuals feel misunderstood, humiliated, neglected, and rejected. Morbidly obese individuals, especially those seeking surgery, report a significantly poorer quality of life.⁶ Prejudice and discrimination against obese individuals begin in childhood, as reported in studies of six-year-old children who described silhouettes of obese children as lazy, dirty, stupid, ugly, cheats, and liars. In this study, children and adults viewed obese children to be the “least likeable” compared to other children with severe handicaps, such as missing hands and facial disfigurement.⁵



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In the literature, there is a consensus that obese people have low employment prospects and are denied educational, vocational, and advancement opportunities.⁶ Studies have reported lower acceptance rates into prestigious colleges for obese high school students compared to their normal-weight peers.⁵ Research has shown that employers view their obese employees to be less qualified for jobs, with poorer work habits, and they are perceived to have increases in emotional and interpersonal problems.³ Many employers limit the weight of employees, such as the military, fire, and police departments and commercial airlines. Discrimination is evident by the lower earning potential of obese employees compared to nonobese employees.⁵

It also appears that more prejudice and discrimination is directed against obese women than against obese men.⁴ Clinical studies have revealed a demographic profile of extremely obese women, which included lower education and income levels, higher rates of household poverty, and lower rates of marriage than nonobese

women.³ Women and adolescent girls appear to be particularly vulnerable to symptoms of low self-esteem and depression.⁷

In a 1990 study of patients who underwent obesity surgery, researchers administered questionnaires to elicit patients' experiences of prejudice and discrimination at work, within the family, within the medical community, and in public places. Preoperatively, patients reported an overwhelming amount of prejudice and discrimination. Specifically, more than 80 percent of patients answered "usually" or "always" to the following questions: "I feel that my weight has negatively affected whether or not I have been hired for a job;" "At work people talk behind my back and have a negative attitude toward me related to my weight;" "I do not like to be seen in public because of my weight;" and "Because of my weight, I avoid fast food restaurants with booths."⁴ Most striking was that preoperatively 78 percent reported that they had always or usually "been treated disrespectfully by the medical profession because of my weight."⁴

CASE PRESENTATION— Continued

During adulthood, Charles reportedly tried numerous local and national weight reduction treatment programs, including Weight Watchers. Quite often he had early success with weight loss that was sustained for many months. Nevertheless, his resolve was challenged with the long-term behavioral component of most programs. To his dismay, he regained the lost weight and then gained more. Some of this weight gain was attributable to medical conditions, which led to inactivity and deconditioning. His medical history is significant for hypertension, chronic asthma and allergies, multiple back surgeries secondary to a motor vehicle accident, and chronic knee and hip pain.

Charles asked about bariatric surgery. He was frustrated by his numerous attempts to lose weight and he was tired of being "fat." Using the internet, he had investigated the surgical options for obesity treatment, and he went to his family physician for a referral. Charles believed he was a good candidate but he wondered what to expect from the psychological evaluation. Charles had no psychiatric

hospitalizations and he never attempted suicide. He had no history of substance abuse or dependence, and he did not meet criteria for any of the eating disorders.

KEY POINTS—What is the Preoperative Behavioral/Psychological Evaluation for Bariatric Surgery Candidates? What are the Psychiatric Conditions that are Contraindications for Surgery? What are the Common Psychiatric Diagnoses Among Bariatric Surgery Candidates?

In the US and abroad, there is no uniform pre-operative psychological evaluation for bariatric surgery. Standards

the patient's medical record. The assessment usually includes an assessment of why the patient is seeking surgery now, whether or not the patient expects psychosocial improvements due to weight reduction, and whether or not these expectations realistic.⁹

There is also no consensus about whether or not psychiatric comorbidities are contraindications to surgery. Some experts report that the only psychiatric contraindication is active substance abuse, while others use the psychological evaluation to "confirm the absence of mental health disorders, such as major depressive episodes, schizophrenia, personality

medical regimens.⁸ Other considerations include preoperative treatment of mania, suicidality, and any current physical or sexual abuse.¹⁰

According to a recent study published in *Obesity Surgery*, bariatric surgery candidates underwent a behavioral/psychological evaluation after their initial consultation with the surgeon. Candidates completed three psychological instruments: WALI (Weight and Lifestyle Inventory), which is used to assess weight and diet histories, eating and activity habits, social functioning and life stressors; QEWP (Questionnaire on Eating and Weight Patterns), designed to

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exist within individual institutions across the nation, and the consensus is that these evaluations should be conducted by a psychologist or psychiatrist who is familiar with bariatric surgery procedures, including follow-up and the required behavioral changes.⁸ Some institutions administer specific psychological instruments, such as the MMPI (Minnesota Multiphasic Personality Inventory) and the BDI-II (Beck Depression Inventory-II), in addition to a clinical interview and review of

disorders, substance abuse, and/or disordered eating behaviors, such as binge eating disorders."³ The Veterans Administration Bariatric Surgery Workgroup excludes patients from surgical consideration if their psychological evaluation reveals the presence of active psychosis, a history of multiple suicide attempts within the past five years, alcohol and/or other substance use disorder within the past six months, borderline personality disorder, or a history of poor adherence with

assess for binge eating and other eating disorders; and BDI-II to assess for depressive symptoms. The purpose of the testing was to evaluate each candidate's appropriateness for surgery, and the results were summarized in a letter to the surgeon, who made one of the following three recommendations: 1) The patient is unconditionally appropriate for surgery; 2) The patient is appropriate for surgery contingent upon receiving psychiatric and/or nutritional counseling prior to

surgery; or 3) The patient is inappropriate for surgery.¹¹

The results indicated that of the 90 patients evaluated, 56 patients (62.2%) received at least one psychiatric diagnosis and one-half of those received at least two diagnoses; six patients received three or more diagnoses.¹¹ Major depressive disorder was the most commonly diagnosed, followed by binge eating disorder.¹¹ More than one-half (64%) of the patients were unconditionally approved for surgery, and one-third (31%) received conditional approval based on additional psychiatric or nutrition counseling.¹¹ Only three patients were not recommended for surgery, and all three had at least one psychiatric diagnosis. The three were excluded for the following reasons: a major depressive episode within the previous month; little awareness of the severity of her current eating behaviors or the requirements of the postoperative diet; and clear motivation for surgery more for appearance than health concerns.¹¹

The conclusions of this particular study were similar to others: Mental disorders do not preclude approval for bariatric surgery; however, in the bariatric surgical community there is no consensus whether psychiatric comorbidity should be considered a contraindication to surgery. Due to the absence of conclusive data on the relationship between preoperative psychopathology and postoperative outcomes, the current practice of the program (reported in this study) is to postpone surgery for six weeks to six months if a patient is judged to have uncontrolled psychopathology or little knowledge of the surgical procedure and postoperative diet.¹¹ Nevertheless, more current research is beginning to

report that psychopathology does decline following bariatric surgery, based on pre- and post-surgery scores on the MMPI-2.¹²

In preoperative clinical interviews of bariatric surgery candidates, the literature suggests that extreme obesity is associated with significant psychiatric comorbidity. Approximately 20 to 70 percent of these patients suffer from a current or past psychiatric disorder.¹¹ Consistent with other studies, the mood disorders are the most common conditions, diagnosed in 19 to 60 percent of patients. Binge eating disorder has also been reported in 10 to 50 percent of bariatric surgery candidates.¹¹ Other conditions include anxiety disorders (including generalized anxiety disorder and social phobia), diagnosed in up to 48 percent of patients, and substance abuse disorders, which were diagnosed in a sizable minority.¹¹ Some studies have shown that practitioners are more likely to encounter dysthymic disorder in obese individuals; these patients often report distress with work or personal relationships and are often binge eaters. Though not surprising, the most universal symptom among obese individuals seems to be body image dissatisfaction, particularly in obese women.⁷

This is a large topic of investigation, and the results of many recent studies indicate further research is needed to generate a consensus regarding potential psychosocial contraindications to bariatric surgery, as well as recommendations for patients who present with psychopathology.³

PRACTICE POINT—Exploring Bariatric Surgery Versus Other Options

The therapist continued to explore Charles's reasons for

wanting surgery at that particular time. Charles reiterated his frustration with dieting and his lack of long-term success with multiple weight loss programs. Additionally he said, "I'm tired of being in pain." Charles hoped surgery would relieve, or at least lessen, his joint pain and asthmatic symptoms. He hoped for more energy so he could begin to enjoy life again.

Charles also shared with his therapist that he was tired of people judging him based on his outward appearance. He wanted admiring glances from women and to feel confident for the first time in his life. Charles was tearful and angry when he told his therapist that his family physician did not think surgery was a good idea, allegedly due to the lack of long-term postoperative data. Charles wanted to know his therapist's opinion regarding his interest in bariatric surgery.

PRACTICE POINT—The Patient Asks for Direct Advice

As with most direct questions in psychotherapy, it isn't the answer that is important so much as the meaning associated with a particular answer. In this case, further exploration revealed that Charles wasn't sure his therapist would be any different than the other people in his life who (he believed) felt it was his fault for being obese.

Charles believed that his family physician, just like his parents, viewed him as lazy and capable of losing weight. He believed the family physician was withholding from him and did not truly care about him.

The therapist encouraged Charles to reframe this situation and explore several alternate possibilities. For example, was it possible that the family physician was showing concern for him regarding the risks of

TABLE 1: Therapy tips for educating the treatment team

- **Encourage patients to tell their own stories concerning how weight has affected their lives; consider asking, “How do you hope that I can help you?” Attentively listen and try to understand the patient’s goals and fears. Try to remain open-minded and compassionate, while not stereotyping obese patients.**
- **Most studies show even when obese patients attempted to lose weight (through fasting, dieting, behavioral/self-management training), 95 to 98 percent did not maintain their weight loss after 3 to 5 years.⁷**
- **Based on two long-term follow-up studies, the mortality rate for bariatric surgery ranged from as low as 0.25 percent to 3.45 percent.^{15,16}**
- **The benefits of weight loss are substantial, especially to the morbidly obese: Medical and psychiatric conditions improve, and most patients report a dramatic improvement in their quality of life.**
- **Despite an overwhelming exposure to daily prejudice and discrimination, a majority of obese patients have essentially normal psychological functioning. Those who are most likely to suffer clinically significant psychopathology are the morbidly obese (BMI >40), women, and those with binge eating disorder.**
- **Most mental illnesses do not preclude a patient from bariatric surgery. The patient with a mental illness should continue to be treated by his or her mental health professional during the evaluation process and after surgery.**

bariatric surgery? Was it possible that the family physician was concerned that Charles was depressed and/or had unrealistic expectations of the bariatric surgery?

The importance of dealing with the relationship Charles had with his family physician became very clear when Charles shifted his focus entirely away from the surgery. Charles spent the next several months exploring the painful rejections he had felt from his own parents while growing up, and he was re-experiencing these rejections in the parental transference he had developed toward his family physician.

KEY POINT—What to Expect if the Patient Ultimately Decides on Bariatric Surgery

As reported in the *International Journal of Obesity*,¹³ a group of researchers

conducted a systematic review of 40 articles to assess the psychosocial outcome of bariatric surgery.¹³ Their results indicated that for a majority of people following bariatric surgery, mental health and psychosocial functioning do improve. Prevalence rates of Axis I psychiatric disorders (especially affective and anxiety disorders) were considerably less at follow-up, ranging from no diagnosis to one-half of the presurgical rate. Personality disorders did not change considerably after surgery, as expected due to their relatively stable and pervasive nature.¹³

Social functioning in general was dramatically improved at two years and four years post-surgery, but obesity-related psychosocial problems turned out to be the most responsive treatment effect of weight reduction. On average, obesity-

related psychosocial problems were reduced two years after the operation by 63 percent in men and 57 percent in women.¹³ A majority of patients indicated a significant improvement in their self-esteem, in satisfaction of their sexual life, and improved educational and occupational status.¹³

Most studies showed that negative psychosocial consequences were atypical in bariatric patients. However, there was a large follow-up of 1785 patients over 1 to 14 years that found eight suicides.¹³ At that time, there was no clear evidence to suggest a higher rate of suicide among post-bariatric surgery patients, but these numbers suggest physicians should carefully monitor post-surgery patients for depression and suicidal ideation. Other psychiatric disorders leading to death post-surgery include alcoholism, bulimia, and automobile accidents associated with substance abuse or behavioral impulsivity.¹⁴

In general, important factors that suggest good postoperative adjustment include a strong social support,³ lack of pre-operative binge eating behavior,¹⁴ and patients who continue to exercise.¹⁵ Other studies suggest the most successful patients were young, were female, were non-smokers, had a lower pre-operative BMI, and had no history of diabetes or hypertension.¹⁵

PRACTICE POINT—Educating the Treatment Team

Therapists can provide immeasurable support to their patients by promoting empathetic physician-patient communication among all members of the treatment team. As illustrated in the case presentation, obese patients (who discuss the option of bariatric surgery with their

primary care physician) may not clearly understand their physician's recommendation(s), and as a result, the patient may attribute his or her own misguided meaning to those recommendations. Many patients may also feel that their concerns and experiences were not heard due to the time constraints placed upon most primary care physicians. See Table 1 for a brief list that can guide therapists in educating the treatment team.

SUMMARY

Obesity is a growing epidemic. Undoubtedly the psychiatrist will be treating morbidly obese patients who will consider and undergo bariatric surgery, regardless of whether we provide medication management or psychotherapy. It is important that we are aware of the psychosocial impact of obesity, including perceived prejudice and discrimination, so we can better understand the impact upon our patients' lives. Although many of us will not complete the formal psychological assessment, we can provide invaluable support to our patients by providing them with information and by instilling hope.

We can share with our patients that on average most patients lose 40 to 60 percent of excess weight post-bariatric surgery. In about 30 percent of patients, weight regain occurs between 18 months and two years post-surgery, but this is often associated with a recurrence of binge eating behavior.¹⁴ We can inform our morbidly obese patients that postoperatively they are likely to have considerable improvement from their medical and psychiatric symptoms and they will likely have a dramatic improvement in their quality of life. Most importantly, their morbidity and mortality from obesity will significantly decline.

Finally, it is essential to remember that obese individuals requesting bariatric surgery have higher rates of psychopathology compared to obese individuals in the general population.⁷ They report an 84-percent lifetime history of major mental health disorders (according to DSM-IV) and up to 72 percent of personality disorders.¹³ Identifying and treating comorbid psychiatric disorders (such as binge eating disorder, mood disorders, anxiety disorders, and substance abuse disorders), as well as monitoring for post-operative substance use,

TABLE 2: Patient and professional resources for bariatrics

American Obesity Association
www.obesity.org

eDiets.com
www.ediets.com

Food and Nutrition Information Center
www.nal.usda.gov/fnic

Obesity Research
www.obesityresearch.org

Obesity Surgery
www.obesitysurgery.com

Overeaters Anonymous
www.oa.org

Partnership for Healthy Weight Management
www.consumer.gov/weightloss

Shape Up America!
www.shapeup.org

Take Off Pounds Sensibly (TOPS)
www.tops.org

Weight Control Information Network
<http://win.niddk.nih.gov>

depression, lack of social support, and/or suicidality, will help to ensure a patient's successful post-operative course. See Table 2 for patient and professional resources.

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